



Draft Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre

Report on the Service User/Carer Consultation

February 2009

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1. Introduction

The Mental Health Commission was established under the Mental Health Act 2001. As determined by the Act [Section 33(1)], the principal functions of the Commission are:

“to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres under this Act.”

In line with its mandate, the Commission felt it appropriate to develop a code of practice on admission, transfer and discharge to and from an approved centre. The primary objectives of having a code are, amongst other things, to create a more positive journey for service users through the mental health service from admission to discharge, and to encourage the active involvement of service users and their families/carers or chosen advocate in admission, transfer and discharge.

The code of practice is being prepared in accordance with Section 33(3)(e) of the Mental Health Act 2001, whereby the Commission shall:-

“prepare and review periodically, after consultation with such bodies as it considers appropriate, a code or codes of practice for the guidance of persons working in the mental health services”.

The Commission intends to publish the final code of practice after the views of all those involved in the consultation exercises have been taken on board. This report presents the findings of the service user/carer part of the consultation process. It summarises service users and carers' views on what they consider to be the important features of the processes of admission, transfer and discharge. It may be beneficial for the reader to read this report in conjunction with the Draft Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre, which was issued by the Commission in November 2007.

2. Methodology

A written consultation exercise was initially carried out between March and May 2008 which invited all key stakeholders, including service users, carers and their representative groups to submit written feedback on the draft code. Very few responses however were received from service users, carers and advocates. The Commission felt strongly that the views of these key stakeholders needed to be heard before the final code of practice was published. As a result, the Commission engaged the National Service User Executive (NSUE) to carry out a consultation exercise specifically to ascertain the views of service users, carers and advocates. The National Service User Executive recommended adopting a focus group approach to this consultation and, in collaboration with the Commission, eight focus groups were organised nationwide.

The National Service User Executive's advisory committee is comprised of members of several voluntary bodies including the Irish Advocacy Network (IAN), Schizophrenia Ireland (SI)¹, Steer, Grow, Aware, Mental Health Ireland, Bodywhys, and Recovery Inc. Contact was made with all of these organisations to inform them of the consultation. Each organisation was requested to advise its members that the focus groups were taking place and each organisation was requested to nominate a facilitator for one of the focus groups.

A total of seven focus groups were held in different locations around the country between September and October 2008. Table 1 overleaf displays the full breakdown of the number of people who attended each focus group by location. A total of 47 service users and carers participated in this consultation exercise.

¹ Now called 'Shine'

Table 1 – Breakdown of Focus Groups Participants by Location

Location	Number Attended	Date
Athlone	2	23 rd September
Dublin	10	24 th September
Cork	14	25 th September
Letterkenny	11	25 th September
Dundalk	2	30 th September
Galway	3	7 th October
Waterford	0	8 th October
Dublin	5	9 th October
Total	47	

Each focus group facilitator was provided with information guides on the consultation exercise to distribute to participants on the day (See Appendix 1). The information guide comprised of a summary of the main points contained in the draft code and four questions to generate discussion in the focus groups. These were as follows:

1. What do you think are the important things that should happen when you are being admitted to hospital or that should happen shortly after being admitted?
2. What things are important to you when your multi-disciplinary team is considering transferring you to another hospital, either because your team feels it may help you or you have requested it?
3. What do you think are the most important things that should happen before you leave hospital?
4. Are there things that you think are important that should happen shortly after you leave hospital? If so what are these things?

All participants were assured that any contributions they made would be treated confidentially and that no information would be revealed in the report which would allow for their identification.

The Commission met with all focus group facilitators following completion of the consultation to obtain all feedback received (See appendix 2 for list of attendees). Section three provides a thematic analysis of the feedback received.

3. Consultation Findings

Section 3.1 provides some general observations which came out of the consultation, followed by the key themes emerging from the focus groups, which are dealt with in Section 3.2. Section 3.3 then provides specific feedback on the content of the draft code. A number of general comments that were not directly related to guidance in the code are also noted in Section 3.4 and suggestions that emerged from the focus groups on how the Commission could improve service user participation in consultation exercises in the future are addressed in Section 3.5.

3.1 General Observations

The majority of the feedback that could be related to sub-sections of the draft code or to specific guidance contained in the draft code was supportive of the current format and content. Many of the participants were unaware of the specific provisions within the draft document, however when comments from the focus groups on what persons perceived to be the important features of the admission, transfer and discharge processes was compared with the document's actual provisions, a remarkable degree of overlap was found.

A large number of comments were also received on issues related to admission, transfer or discharge but which it is felt were outside the scope of the code of practice or were more general in nature. Section 3.4 highlights these issues.

3.2 Key Themes

A number of key themes came out of the consultation. These were as follows:

Dignity and Respect

In a number of focus groups, the importance of upholding a person's dignity and respecting his or her right to privacy was highlighted. Participants stressed that the trust of residents can be gained where a culture of respect and dignity prevails.

Concrete examples of how dignity and respect could be nurtured included granting access to private or family rooms when persons are admitted to hospital and taking account of the fact that much of the admission process occurs in public places. Examples of actions which did not uphold a person's dignity or show respect included the removal of personal possessions and a prohibition on a person wearing his or her own clothes.

Need for Compassion

Related to the above theme was the focus of some feedback on the need for staff to show compassion at all stages of a resident's stay in an approved centre. One participant stated that *"you shouldn't be made to feel like you did something wrong"*. Admission to an approved centre was frequently described as a scary or frightening experience and some participants thought it important that staff reassure them. One service user recalled a member of staff in an approved centre who introduced herself and displayed human qualities. This was identified as an example of compassion in action.

Communication and Information Provision

The importance of open communication between staff and residents and the need for residents to be provided with information on a number of issues was frequently highlighted. A number of focus group participants noted that they did not understand how the system worked and therefore, having information on issues as diverse as meal times, arrangements for washing clothes, medication, specific treatment interventions or the reasons why they are being transferred was important. Everything should be spelt out clearly.

Person Centred Services

The importance of services focussing on the service user was also frequently noted. Comments suggested that this could be achieved by respecting a patient's privacy and allowing him or her to wear their own clothes for example. Services should function with the best interests of the service user in mind and actively strive to listen to him/her. One comment stated that negotiation between staff and service users should characterise many of the aspects of the admission, transfer and discharge processes. No care or treatment options should be imposed on anyone for instance.

Ethos of Recovery

Some respondents also commented that the draft code did not adequately reflect the ethos of recovery which they felt was critical to the admission, transfer and discharge processes. A number of participants noted that the word recovery did not feature at all in the document. Where the issue of recovery was highlighted in focus groups, comments noted that an ethos of recovery should begin immediately on admission and should permeate the individual care and treatment plan for instance.

Avoidance of Jargon

Some contributions identified what was regarded as perceived jargon that was present in the draft code or the consultation information guide. It was felt that plainer language should be used and medical jargon avoided. Terms such as multi-disciplinary team were, for example, not favoured by some participants.

Privacy, confidentiality and consent

Consultation responses also regularly identified the importance of respecting a resident's right to privacy, upholding the duty of confidentiality and requiring consent before proceeding with a range of actions. Areas where this theme was brought up ranged from the involvement of family members in the admission, transfer and discharge processes to the transfer of information between health professionals and other agencies.

Continuity of Care

The need to ensure continuity in care was identified in some focus groups, particularly when participants concentrated on the transfer and discharge processes. Participants noted that care plans should accompany residents when transferred, for instance, and that service users should not be transferred to an approved centre with inferior care and treatment. Furthermore, frustration was expressed that different clinicians than those from whom treatment is received in approved centres are often seen at follow – up appointments following a person's discharge.

3.3 Specific Feedback on the Draft Code

This section of the report details focus group feedback that can be related specifically to the content of the draft code. In the case of each of the three processes, feedback is categorised according to the different sub-sections of the code. Where no content is included on a code's sub-section, this is because no specific feedback from the focus groups was received on this area.

3.3.1 Admission Process

Pre-Admission Process

One comment received on this area supported the planned approach that characterised the draft code's guidance on the process.

Although the draft code contains a range of guidance on rights and information, no specific mention is made of this issue in the sub-section on the pre-admission process. However, one participant stated that it is important that service users have prior warning of what will happen once they are admitted.

Decision to Admit

The draft code of practice notes that "*residents should be admitted to the unit most appropriate to their needs*". A comment from one focus group which supported this guidance was that it is unfair to have persons that are very unwell with those who are not as unwell.

Assessment

Most comments received were supportive of the prominence given to assessment in the code's guidance on the admission process. More specific feedback included a comment that assessment should be undertaken before a decision regarding admission or non-admission is taken.

Other suggestions were received on the form and content of the assessment that should take place after admission. Among the comments received were that such an assessment should include a physical health assessment which is already included in the draft guidance. Another suggestion was that assessment should also include a dental health assessment.

Rights & Information

Consistent with the key theme of communication and information provision identified in Section 3.2, a number of comments stressed the importance of the provision of information on a variety of issues and that residents should have knowledge of their rights.

Comments questioned where information on rights was “*for reading or display*” in the approved centre. In addition, comments from one focus group noted that consideration should be given to a person’s mental state on admission so that information should be relayed again when a person is feeling better.

The draft code includes references to the adaptation of information in form and content to meet the needs of the resident and to the availability of information booklets in other languages. One focus group participant stated that the code should include a provision that requires approved centres to have interpreters for non-national service users, when needed.

In two focus groups, the importance of residents being introduced to staff in the approved centre was noted and one participant recalled an occasion when introductions by a friendly member of staff reassured him/her.

Individual Care and Treatment Plan

The individual care and treatment plan was identified as an important issue in several focus groups. Comments from two focus groups noted that care planning should take place as soon as possible after admission.

Most contributions relating to the plan included suggestions regarding its content. Among those received were that the care and treatment plan should:

- Explain how to access advocacy services;
- Include timescales, including an expected discharge date;
- Include social activities;
- Include counselling; and
- Include educational content.

Other comments insisted that the plan should contain positive messages, be clear on the benefits of care and treatment and be regularly reviewed. Linked to the key theme of the need for a recovery ethos, was the expressed disappointment that the draft code’s provisions on the individual care and treatment plan did not mention the word recovery.

Key Worker

The crucial role played by the key worker in the admission process was also highlighted. However, the majority of the feedback that was received on this position highlighted areas where service users felt that the key worker system was not operating as effectively as it should be.

Among the points made were:

- There is no continuity in key worker between admissions;
- No set time with the key worker is allocated;
- No choice is given in the allocation of key workers; and
- There is a lack of privacy in interactions with key worker.

Resident & Family Involvement

A number of comments emphasised the importance of the involvement of families, carers and advocates in the admission process with consent.

Record Keeping and Documentation

In one focus group, the issue of record keeping and documentation received considerable attention. Feedback from the participants noted that the recording of information should respect the consent process.

One comment stated that teams should work to one set of documentation.

Concerns emerged about the recording of some of the information, particularly in relation to information on a resident's diagnosis. Comments stressed that diagnosis is an opinion at a time, that labels can frighten and that it should be possible to challenge some of the information that is collected on residents.

The importance of records being legible emerged from another focus group.

Day of Admission – Some Practical Considerations

Most feedback that was received in relation to practical considerations on the day of admission focused on the area of personal property and clothing. Comments were characterised by a strong belief that residents should have access to their belongings and that a denial of access did not uphold a person's dignity.

Guidance in the draft code provides scope for the removal of a person's clothing following a risk assessment although a provision is included that clothes should in general not be taken from residents on admission. In a number of focus groups, the belief that residents should have the free choice to wear their own clothes emerged. Recounting a past experience, one service user queried why his/her mobile phone was removed during his/her admission.

Other Points

A contribution from the consultation that is currently not directly addressed in the draft code in relation to admission is the suggestion that private rooms be available for persons which they can avail of prior to and while they are being admitted. This point was raised in two focus groups. It was noted that "*a person may need a quiet space before everybody becomes involved*" and that admission often takes place in a public place which is viewed as inappropriate.

3.3.2 Transfer Process

Transfer Criteria

The majority of focus groups gave feedback on the transfer criteria that were outlined in the draft code. The opening criterion notes that when considering the transfer of a resident: "*It is in the best interests of the resident to be transferred to another facility*".

There was general support for the principle of best interests of the resident being an important consideration in the transfer process, although clarity on what is meant by best interests and which person decides what is in the best interest of the resident was sought.

The second element of the transfer criteria states that:

"The person is in need of obtaining special treatment or care that can only be provided in another facility".

As was the case with the principle of the best interests of the resident, a request to clearly define special care and treatment emerged from one of the focus groups. Other participants suggested that it would be useful if the code gave examples of special care and treatment.

The final element of the transfer criteria states:

"The resident requests to be transferred either to another approved centre, which may be closer to his/her home or to an independent facility for which he/she has medical insurance cover".

One participant suggested that the code should outline more clearly why a person might want to be transferred. Referring to the examples above, he or she noted that a person may want to be close to home or in other cases far away from home. In another focus group, the view that persons should be able to avail of services about which they have received recommendations was expressed.

A large number of comments were received on the wishes of the resident regarding the transfer and in particular, a recurring point that was made in focus groups was that a right not to be transferred should exist i.e. residents should consent to all transfers.

Among the other comments received that related to transfer criteria were a recounting of past negative experiences of transfer. Some service users spoke of transfer being used as a threat or punishment and of persons being threatened with a tribunal if they did not consent to a transfer. For these reasons, it was felt that the code should clearly establish that transfer should not take place for “*bad behaviour*”.

Respondents to the consultation also noted that equity between the facilities involved in the transfer was important and that care needs should be part of the transfer considerations.

Emergency Transfers

One comment was received on emergency transfers. The code states that “*the resident should be assessed to ensure his or her safe transfer to another facility*”. A request to define what is meant by safe emerged along with a concern that safety considerations not be used as an excuse for not transferring a resident.

Assessment

The draft code’s provision on assessment states that “*clinical risk assessment should be an integral part of the assessment of the patient prior to transfer*”.

One contribution sought a strengthening of this provision by insisting that the code should explicitly state that a person “must” have an assessment before they are transferred. Another contribution requested that the code clarify that an assessment before a transfer should represent continuity with previous assessments i.e. a complete re-assessment is not necessary.

Resident and Family Involvement

The majority of responses relating to resident and family involvement in the transfer process focussed on the resident's choice and his/her wishes towards the transfer. The draft code currently notes that "*every effort should be made to respect the resident's and his or her family's/carer's wishes regarding the transfer.*"

Among the feedback received were comments that stressed the importance of establishing the resident's known wishes and of consulting with his/her friends and family. A strong belief that the transfer should be discussed and agreed with the service user was present in a number of focus groups. The service user was described as the expert in his/her own care and as such, he or she should be granted the choice of whether he or she wants to be transferred and the choice of where he or she wants to go. A sense that an absence of choice characterized the transfer process and that this disempowered service users was evident.

Other comments related to resident and family involvement were similar to those made on the admission process i.e. that the involvement of carers and families should be encouraged but that it was very important that residents consent to such involvement.

Another participant suggested that a note on the involvement of advocates should be added to the code's guidance on this area.

Communication

Feedback received on the code's provisions on communication during a transfer was primarily general in nature. Contributors stressed the importance of "*good communication*" and others noted that "*follow up communication between centres was important*". Other responses stated that a person's care and treatment plan should follow them on transfer.

Record Keeping & Documentation

Similar to the feedback on communication, comments which referred to record keeping and documentation were primarily general in nature. It was noted that "*good records should go with the person*" and that "*records must be kept of the process and explained*". The importance of upholding a person's right to privacy when recording information on the transfer process was also noted.

Day of Transfer – Some Practical Considerations

The final section of the draft code includes a number of points that focus on practical considerations relating to transfers. The opening point includes a statement that “*planned transfers should take place early in the day and before 17.00 hours in so far as is practicable*”. Feedback from one focus group stated that “*transfer should only take place during the day, not at night, even within a service*”.

A number of contributions stated that the admission policy of the receiving facility should be implemented when a resident arrives at a new unit.

Other comments on this area included references to the form of the transfer and staff involved in carrying it out. For instance, it was noted that “*personnel involved in the transfer should be in plain clothes*”, that transfer should be carried out “*by trained persons only*” and that “*force should not be used during transfers*”. Another contribution made the point that the “*person being transferred should not be under restraint*” and another noted that it was important to “*avoid heavy handedness*”.

Other Points

Additional feedback on the transfer process included the suggestion that the key worker travel with the resident while he or she was being transferred. Some participants called for a sub-section on “*rights and information*” similar to the sub-section that exists in the admission process section.

3.3.3 Discharge Process

Discharge Planning

Discharge planning was highlighted a number of times in the consultation. Feedback included statements which identified proper discharge planning as “*important*” and identified “*a need for discharge management from the point of entry*”.

Contributions that referred to the content of the discharge plan varied. There were calls for the inclusion of an expected discharge date and another participant stated that the discharge plan “*should have more information on a person's background and interests*”.

Pre-Discharge Assessment

Of the feedback received in relation to pre-discharge assessment, most concentrated on the housing component of such assessments. Comments included the view that everybody should be discharged into a safe environment and that “*suitable accommodation should be secured for everyone before they are discharged*”. It was noted in one focus group that a pre-discharge assessment should include a physical assessment which is not currently specified in the draft code.

Key Worker

The significant role played by the key worker in approved centres was also acknowledged in comments related to discharge. It was suggested that the key worker “*should liaise with the social worker and local voluntary support*”.

Resident/Family Involvement

Support for the involvement of families and carers, with consent, was also evident in discussions on the discharge process.

In one focus group, it was noted that all parties should be consulted and agreement reached on where a person should be discharged to. One contribution stated that the “*carer should be able to say no*” although it was not clear if this comment came from a carer or service user.

Information Provision

The majority of focus groups included specific suggestions on the type of information that should be given to residents, families and carers upon discharge. Suggestions included information on:

- Multidisciplinary teams;
- Support services;
- Emergency phone numbers;
- Medication/Prescription;
- Treatment;
- Returning to work;
- Accommodation;
- Self-help groups; and

- Occupational therapy.

Notice of Discharge

Two comments emerged in respect of the draft code's section on discharge notice. Firstly, one contribution noted that the document's provision that residents be given at least two days notice of discharge was too short. The other contribution referred to the form of the discharge notice which is not currently specified in the draft code's guidance. This feedback stated that the notice of discharge should be given verbally in person and not by voicemail or letter.

Follow-Up and Aftercare

The draft code's content on follow-up and aftercare focuses on appointments following discharge.

Where comments were received on this area, almost all contributions strongly supported a short time span between discharge from hospital and the arrangement of such an appointment. One participant noted that "*follow up appointments shortly after leaving hospital is important*".

In another focus group, the view was expressed that residents should be seen at follow-up appointments by the same psychiatrist that he or she received treatment from in the approved centre.

One of the draft code's provisions states that "*it is considered good practice that individuals with severe mental illness and a history of deliberate self-harm within the previous 3 months or who are assessed as being at high risk of suicide should have a follow-up appointment within one week of discharge*". Comments on this provision indicated that there needs to be scope in the code for considering appointments within less than one week of discharge. Among the suggestions received was that there should be a phone call within days of discharge for high risk residents and that more use should be made of support workers and home visitors for high risk individuals.

One participant also noted that there should be flexibility between appointments and service users should be allowed to make contact where necessary in between follow-up appointments.

A number of items were identified in some focus groups as crucial to the care and well-being of a resident on discharge and which should be followed – up and delivered on with the permission of the resident.

These included:

- Financial arrangements/social welfare/entitlements;
- Food/Arrangement of meal on arrival;
- Fuel;
- Accommodation/House preparation/Home-help; and
- Personal requisites.

Day of Discharge – Practical Considerations

One comment noted the importance of travel arrangements when considering practical issues on the day of discharge.

Specific Groups – Homeless People

The need for discharge processes to take account of the specific needs of homeless persons was stated in a number of focus groups.

3.4 General Comments not related to the Draft Code

A significant amount of the feedback from focus groups related to issues that were not directly addressed in the code but were more general in nature. This report does not address all of these issues in detail but categorises feedback into four main areas for which numerous comments were received.

Service Provision

In certain focus groups, participants expressed frustration at what they regarded as poor service provision which hampered the delivery of effective mental health care and treatment. In some focus groups, there was criticism of the lack of alternatives to hospital admission. Comments included a note that more community based recovery interventions, safe houses and better psychiatric training of GPs would lead to fewer admissions.

Participants noted that services were patchy on the ground and that more choice within the locality and particular mental health facility would reduce the need for transfer. Frustrations were also noted at what was perceived at the lack of implementation of mental health policy.

Criticism of Staff

Criticism of mental health service staff also emerged in the consultation exercise. Comments included concerns over the quality and qualifications of staff who were regarded by some as needing more training and education. Among the more specific criticisms were that staff displayed unprofessional attitudes, viewed advocates with suspicion and were unwilling to engage with advocates and relatives.

In one focus group, some of the debate centred on allegations of past abuse by staff against service users. There was a call for the abuse experienced by service users to be properly acknowledged. It was stated that people who abuse residents should be brought to task in some way. On foot of this feedback, the Commission requested that facilitators provide the Commission with further information on any specific complaints made.

Regulations

A large number of comments that were received as part of the consultation addressed issues that are either directly or indirectly addressed in the Mental Health Act 2001 (Approved Centres)

Regulations 2006. For instance, access to water, snacks and food, telephones and visitors were all raised in different focus groups.

Medication Concerns

Concerns about medication were also regularly raised by participants. In particular, some contributions were critical of the lack of alternative therapies to the medical model which was regarded as characterising treatment in approved centres. Concerns were expressed over the consequences and side effects of taking medication. A call for more information to be made available on medication i.e. its side effects and when it should be taken was also frequently heard.

3.5 Suggestions for Future Consultations with Service Users

There were a number of suggestions on how the Commission might continue to improve levels of service user, family/carer and advocate engagement in consultations going forward, which came out of the follow-up feedback session with the focus group facilitators. Relevant comments were also made at the focus groups.

Key recommendations were as follows:

1. Provide as long as possible a lead in time to consultation;
2. Advertise as much as possible. Local advertising may be most effective;
3. Hold focus groups in the most convenient locations possible. Places where people have day activities were suggested e.g. day hospitals, out-patient departments and inpatient units. Hotels are fine but may be less accessible to people; and
4. Local facilitators may be best placed to decide where best to hold focus groups.

In one focus group, several limitations to the approach adopted in this consultation were highlighted. These were as follows:

- A service user did not facilitate all of the focus groups;
- It was inappropriate to include service users and carers in one focus group. The service user perspective is unique;
- Not enough notice was given to service users;
- The time arranged for the focus group was inconvenient; and
- No sampling method was used.

A suggestion that emerged from this focus group was that a service user consumer panel could engage with the Commission to put forward the service user perspective.

One service user who participated in one of the focus groups subsequently made contact with the Commission to express concern over the representativeness at the focus group at which he attended. Useful suggestions were made by him as to how NSUE could ensure representative participation in the Executive as a whole.

All of above points will help guide the Commission in future consultations that it carries out.

Appendix



Service User / Carer Consultation
on
Draft Code of Practice:
Information Guide

August 2008

1. Introduction

The Mental Health Commission has developed a draft guidance document on admission, transfer and discharge to and from inpatient mental health facilities. This document is a draft document only, meaning that it is not the final document. The final document will be published after the consultation process is complete and the views of those involved taken on board. It will then be sent out to mental health services and services will be expected to follow the guidance contained in it. The draft document has been put together following a review of the literature on the areas of admission, transfer and discharge from hospital. This literature comes from Ireland and also countries abroad such as England, Scotland and Australia. A multi-disciplinary group of staff within the Commission put the document together.

There are several reasons why the Commission feels this guidance is necessary. In the consultation that the Commission had for the Quality Framework for Mental Health Services in 2005, for example, people using mental health services said they wanted continuity of care and support from first contact with services to discharge planning and aftercare. Families, parents and carers in this consultation highlighted the importance of discharge planning in hospital and follow up and aftercare as integral parts of discharge planning. Continuity of care and discharge planning are key themes of this draft guidance. The Commission also believes that there is a strong need for consistency in the processes of admission, transfer and discharge to and from hospitals around the country so that regardless of where a person goes for inpatient care and treatment for their mental health problems, they receive the same high quality care.

The Commission carried out a written consultation on the draft document between November 2007 and April 2008 where people were asked for their views on the document. Several people wrote into the Commission with their views, but very few people using services or the families or carers of people using services sent in comments. The Commission feels it is very important to have the views of people who have experience of using services as well as those of carers and families reflected in this guidance before it is published. As a result, the Commission is organising several focus groups specifically with service users and carers so that their views on these issues can be directly discussed.

2. Focus Groups

The Commission has invited the National Service User Executive (NSUE) to carry out the focus groups on behalf of the Commission. Any information given at the focus groups will be treated as **strictly private and confidential**. Involvement in the focus groups is completely **anonymous** so the Commission will not know who has attended the focus groups. The National Service User Executive will feedback information to the Commission on the number of people who took part in the consultation and the key issues that people brought up in the focus groups. This information will then be considered by the Commission before the final guidance document is published.

We wish to seek your views on the proposed guidance. We would like to know what things you consider important when being admitted to hospital for care and treatment for mental health problems. We also want to know what factors you think are important when being transferred to another hospital for care and treatment. And, when being discharged from hospital back into the community, we wish to know what things you feel should take place before and after this happens.

3. Summary of the Key Issues Contained in the Draft Guidance

(a) ADMISSION

Some of the areas that came up as being important for admission both in the literature and from the group of people within the Commission developing the guidance document were as follows:

1. Admission should be a **planned** process where possible so that everyone involved in admission is prepared for it and has all the information they need.
2. Services should have in place a process for **unplanned** referrals as sometimes a person may need to be admitted to hospital in an emergency situation.
3. The **decision to admit** should be made in consultation with the person, family/carer (with consent), members of the multi-disciplinary team.
4. If a service user is **not being admitted**, he/she should be told the reasons for this and referred to a more appropriate service if necessary.
5. Everyone should have an **assessment** on admission.
6. A service user should receive all **relevant information** including information on their **rights** following admission.
7. An individual **care and treatment plan** should be developed soon after admission and discharge planning should be a part of this plan.
8. An inpatient should be introduced to their **multi-disciplinary team** as soon as possible following admission.
9. Everyone admitted to hospital should be assigned a **key worker** on admission who can be a point of contact for them and their family/carer (with consent) and answer any questions they may have
10. A person's **family/carer** should be involved in the admission process with the person's consent
11. Inpatient services need to have a **procedure for communicating** and transferring information to a person's GP and community mental health team, but this procedure should respect the person's right to privacy and confidentiality
12. Inpatient settings should have **one set of records** for a person in hospital and these records should be complete, accurate and legible.
13. Hospitals should work with social, housing and homeless agencies when a **homeless person** is admitted for their mental health problems

Summary of the Key Issues Contained in the Draft Guidance

(b) TRANSFER

Some of the areas that came up as being important for transfer both in the literature and from the group of people within the Commission developing the guidance document were as follows:

1. Transfer should only happen when it is in a person's **best interests** or the person **needs special care or treatment** that they can only get from another facility or they **ask** to be transferred to another facility
2. The **decision to transfer** should be made in consultation with the person, family/carer (with consent), members of the multi-disciplinary team.
3. Hospitals need procedures for **emergency** transfers and such transfers should only take place when it is safe to do so
4. A person should have an **assessment** before they are transferred
5. A person's **multi-disciplinary team** should be involved in the transfer process
6. A person and their **family/carer/chosen advocate** (with consent) should be involved in transfer process and any concerns or questions raised should be addressed.
7. It is important that there is clear verbal and written **communication** between the hospital transferring a person and the hospital receiving a person for care and treatment, and that all **relevant information** is transferred from one facility to another (with consent).
8. **Good records** should be kept of the transfer process
9. Transfers should take place **during the day** and if this does not take place a record should be kept of why it did not.

Summary of the Key Issues Contained in the Draft Guidance

(c) DISCHARGE

The areas that came up as being important for discharge both in the literature and from the group of people within the Commission developing the guidance document were as follows:

10. The **decision to discharge** should be made in consultation with the person, family/carer (with consent), members of the multi-disciplinary team.
1. **Discharge planning** should start as soon as possible after a person is admitted to hospital.
2. A person should have a **comprehensive assessment** before they are discharged.
3. A person's **multi-disciplinary team** should be involved in their discharge.
4. The person's **key worker** should co-ordinate the discharge and contact all relevant people.
5. **Community mental health staff** should be involved in the discharge and sent a **discharge summary** which includes all relevant information on the person.
6. A person and their **family/carer/chosen advocate** (with consent) should be actively involved in the discharge process and given comprehensive information particularly on support services and follow up arrangements before the person is discharged.
7. A person and their family/carers should be given at least 2 days **notice of discharge**.
8. **Follow up and aftercare** are important. A person should have a timely follow up appointment and for those who are high risk, this appointment should be within one week of discharge.
11. **Good records** should be kept in the person's clinical file of the discharge process.
12. Appropriate arrangements should be made on discharge in relation to returning **personal property, providing a medical certificate and transport arrangements**.
13. It is important that arrangements are made for securing suitable accommodation for **homeless people** before they are discharged.

Summary of the Key Issues Contained in the Draft Guidance

- Another important issue in the guidance which is relevant for all three processes: admission, transfer and discharge, is that of **Privacy and Confidentiality**. The Commission believes that information should be handled with the highest level of professionalism and consent should be sought from the service user before personal information is transferred to another health professional.
- **Privacy** is the right to control how your information is obtained, used and disclosed.
- **Confidentiality** is the duty that a person owes to safeguarding information that has been entrusted to him or her by another.

4. Focus Group Questions

Admission

- What do you think are the important things that should happen when you are being admitted to hospital or that should happen shortly after being admitted?
- Use key issues on page 3 to guide and prompt discussion.

Transfer

- What things are important to you when your multi-disciplinary team is considering transferring you to another hospital, either because your team feels it may help you or you have requested it?
- Use key issues on page 4 to guide and prompt discussion.

Discharge

- What do you think are the most important things that should happen before you leave hospital?
- Are there things that you think are important that should happen shortly after you leave hospital? If so what are these things?
- Use key issues on page 5 to guide and prompt discussion.

General

- Any other comments/anything left out?

Appendix 2

List of attendees at Follow up Feedback Session

Mr. John Redican (NSUE)

Ms. Jennifer Kelly (NSUE)

Mr. Leo Patterson (Grow)

Ms. Tricia Kelly (STEER)

Ms. Finola Colgan (MHI)

Ms. Jutta Kirkmann (IAN)

Ms. Patricia Gilheaney (MHC)

Ms. Lisa O' Farrell (MHC)